California Commission
on
Health and Safety and Workers' Compensation

MINUTES OF MEETING

Meeting Day and Date: Thursday, September 10, 1998

Meeting Location: Junipero Serra State Building
107 So. Broadway, First Floor Auditorium
Los Angeles, California

Commission Members Present:

Commissioner Leonard C. McLeod
Commissioner Gerald O'Hara
Commissioner Kristen Schwenkmeyer
Commissioner Robert Steinberg
Commissioner Darrel "Shorty" Thacker
Commissioner Gregory Vach

Commission Members Absent

Chairman Tom Rankin
Commissioner James J. Hlawek

Commission staff:

Christine Baker, Executive Officer

I. Call to Order

The meeting was called to order by Commissioner Gerald O'Hara at 10:00 am. Commissioner O'Hara presided as acting chairman for this meeting since Chairman Rankin was unable to attend.

Adoption of Minutes

A motion to adopt the minutes from the June 25, 1998 Commission meeting was made by Commissioner McLeod and seconded by Commissioner Thacker. There were no objections and the minutes were adopted as submitted by Executive Officer Christine Baker.

II. Presentation on Integrated Health management in San Bernardino County Phillip L. Polakoff, MD, MPH, Integrated Health Management Associates

Executive Officer Christine Baker introduced Dr. Phillip L. Polakoff, President of Integrated Health Management Associates. Dr. Polakoff has worked with both labor and management to create what he calls a unique workplace for workers with savings for management.

Dr. Polakoff reported on a project that is being undertaken in San Bernardino County to deal with an integrated approach to the issue of employee heath and productivity. The goal of project staff was to come up with a way of maximizing productivity and optimizing health for the individual, organization, community, shareholder, and taxpayer. The challenge was in developing a win-win situation that both labor and management could agree on and that would increase competitiveness and productivity.

According to Dr. Polakoff, the world is different than it was five and ten years ago -- unemployment is at an all time low and the need for good employees is higher than ever. Costs continued to rise. All of a sudden there was a quiescent period of discounted workers' compensation. Adding to the environment is Group Health which is well over a trillion-dollar issue and this year, Kaiser increased CalPers by 10.75%, equivalent to a 50 million-dollar increase. But what is the industry getting in return? If you're the employer or employee and are paying more for health care and workers' compensation and are not getting back to the job with quality care, timely care and increased functionality, then it is a losing situation.

The challenge for Dr. Polakoff was how to look at the cost. For over 120 million people in the work force, the average cost on lost productivity for not being at work is $11,000 per year. Employees are off of work for a variety of reasons including both occupational and non-occupational health reasons. More people spend time off of work for non-occupational injuries than occupational injuries. The cost for non-occupational lost time is higher and it is managed more loosely.

The issue of personal leave is becoming more important. Personal leave for childcare and elder care has become a critical issue in the 1990s. Employee absenteeism is very different than it was several years ago. Employees are now owning up to the fact that they are off work for personal reasons not health reasons. They can't take care of their child or mother. They have transportation issues or housing issues and can't get to work. Telecommuting has helped but also created another issue.

A vast majority of workers in the United States say that family issues contribute significantly to their life stress issues. How an employer relates to these issues is highly variable. Hewlett Packard and Southwest Airlines both cater to child care issues while a lot of companies put this on the back burner. So on the work-life initiatives, the impact is to improve employee satisfaction retention, enhance employee initiative, commitment and productivity, reduce stress and burn out, increase customer satisfaction and retention, and create a meaningful work environment.

Dr. Polakoff said that the health care arena has moved from indemnity to managed care. He said that he doesn't think managed care has lived up to its billing. People are getting lost in this healthcare delivery system daily. It is costing employers from a cost perspective and it is costing customers from a quality of life perspective.

So Dr. Polakoff is pushing a concept called total health and productivity or employee health and productivity. Risk management in his view is more reactive than proactive. Under his concept, the questions was how to make something that's very proactive and create an environment where labor and management can come out both ahead and have more to show at the end of the day rather than giving it to ancillary vendors.

The health care industry has undergone recent evolutions. The Family Medical Leave Act (FMLA) is having a major impact on the employer community. The Americans with Disabilities Act (ADA) is having almost no impact. Major cases have been tried but few have been accepted from the employee perspective. Whether right or wrong, it is not having the impact that many people expected. FMLA has had a significant impact that is going to cost many employers significantly in the future.

In order to redefine health management, Dr. Polakoff stated that it is imperative that the focus shifts from prevention to recovery. He said that it is also important to look at the entire spectrum rather than focusing on what happens after a person is injured. He said the focus should begin from the day of hire.

Dr. Polakoff said that they are trying to elevate this issue so it will get more attention from the CEO level and senior HR level and operation level rather than just at the staff level so they have an ownership in it. They are looking at an integrated approach as an investment on productivity and taking on the work life initiatives. The program is a merger of wellness, safety, workers' compensation, and risk management. Employers are paying high dollar and should be getting wellness and safety programs built into their premium, but it is not being done.

Dr. Polakoff described a model program performed in San Bernardino County that has been successful. Although it is not a perfect model, it has shown tangible results in a timely manner.

Barbara Musselman, Human Resources Director, County of San Bernardino

Barbara Musselman, Human Resources Director of the County of San Bernardino, said that it was a complicated problem that spills over to various organizations. Seeing frequent flyers in the workers' compensation arena, it was pretty apparent to her organization that something needed to be done differently. So they sat with their labor association that represents approximately 10,000 - 15,000 of their employees and asked them to identify some of the problems with access to the health care system, whether an occupational or non-occupational injury, and the injured worker's experience in returning to work. Then they asked what they could do to work together to try to address the problem. She stated that she was not concerned whether the injury was occupational or non-occupational. The question was how they can help employees navigate an increasingly complex healthcare system. How are they going to keep the doctor informed about what is the central job function for the employee? What could we do to expand the modified duty to give the employees a choice of coming back even though it is a non-occupational kind of injury.

To answer these questions, some focus groups representing San Bernardino County's largest department, Social Services, were put together. From the focus groups, they found a lot of information. The program design combined the best public and private practice models. The Board of Supervisors approved the pilot of the program. There was oversight from senior management but the key factor was employee involvement. They made a lot of progress by first asking people what is wrong with the system that is designed to serve you. In getting that input, it enabled them to go ahead and put a program together.

Geographic spread was an issue taken into consideration. They have a $1.5 billion budget and have a significant number of lost time. An additional factor, was a large down sizing in the early 1990's causing additional stress on the employees and the impact when someone was ill was felt even more.

The most positive feedback they have received is that it has assisted employees in getting the appropriate medical care in a more timely fashion and in a fashion that helps them return to work more quickly whether it is an occupational or non-occupational injury.

Dr. Polakoff

Dr. Polakoff stated that it took some effort to align all of the players. It is not a static program. It keeps changing as time goes on and appropriate changes need to be made.

Workers' compensation costs for San Bernardino County are about $9.1 million and sick leave is $21.1 million, not including active health premium costs, which totals approximately $50 million dollars for the county. Combined, Workers' compensation and sick leave was $30.2 million. They believed that, through this program, they could achieve a 10% to 15% reduction in those costs by managing them better.

With this the work policy and procedure manuals were all re-drafted, bringing up from the 1980 to the millenium so they had a currency to them. The county hired two care coordinators to deal with this issue on site to keep confidentiality intact. They worked to advocate the employees' health needs, evaluate cases to determine the type, necessity and appropriate level of medical care, interface with the modified duty coordinators, and provide a patient with injury/illness expectation so injured workers knew where they could get care in a timely manner. They interface between the health plan insurer carrier, the employer and modified duty coordinator, the professional medical provider, and case manager. This person is dedicated on site to coordinate among labor, management, employer, provider and insurance carrier. Under this program, they have been able to get people to the physician in a much more timely matter than ever before.

They also offer preventive and wellness programs. Last year they gave 3,500 flu shots to active employees. This year, they will probably give out 5,000+ flu shots to all employees and their dependants on a voluntary basis throughout the county. They also offer weight reduction programs, walking programs and the like. They report an incredible amount of participation by the work force.

They have talked about setting up a new center for employee health and wellness, which is a state of the art clinic, to serve initially all the employees within the county's geographic area. They are also setting up an ancillary in the new County hospital. The center will offer all services needed to provide quality care. There is an advisory board to the Center, which has labor/management representation across all jurisdictions. So it will be their center, owned by the employees and the county, and not just owned by some external entity.

Dr. Polakoff said that it was critical to continue provider education and that they are working with the health plans. Together with Kaiser, Aetna, and Blue Cross they put on their first education programs for these three entities, bringing in the non-occupational doctors into the system for the first time. On March 3, 1999, Kaiser, Aetna and Blue Cross are jointly sponsoring and paying to educate all the doctors in the San Bernardino area on what it means to return county employees to work in a timely manner. Dr. Polakoff invited all interested parties to attend.

Dr. Polakoff then focused on return to work programs. He said they have modified duty coordinators both from the staff position as well as in every operating division to make sure the people can get back. They are redoing all of job analysis for the key position, so the doctors in the community will know the exact job specification for the individual working, so they have clarity on how they should get back to work.

Dr. Polakoff said that the program satisfaction survey is critical. Everything is monitored through surveys and focus groups. So far the response has been overwhelmingly positive.

They are trying to capture the numbers on the program. The County has done something that is probably unique in the United States. They have invested in creating an entire new software system to capture all of their data relating to health and productivity using state of the art

technology which will be on line starting in January or February, tied in with another program. So they will able to see who is off work, why, and the cost. It will capture the numbers that until now have not been able to be captured because the numbers didn't exist, or the technology wouldn't let you capture it. In addition, there is now a way of holding the providers accountable and monitoring who is off work division by division and year to year and how that impacts the bottom line.

In the Pilot project, not including start up costs and based on a population of 400 for non-occupational time and hours off, they saved approximately 4,000 hours or $60,000. If it continues at this level, in the course of the year for the 3300 people in the Social Service Group, they will be able to capture about 1 million dollars with 75,000 hours. That is a significant amount of work force being directed in a very positive way rather than sitting home and doing things that do not help achieve good health.

When the program is better defined, this program will next be extended to the Sheriff's Department as well as in County Medical Center.

To enhance risk management services, Dr. Polakoff said they re-looked at the entire managed care delivery system within the county and submitted a Request for Proposals (RFP) that is down to the finalists now. At the same time, the County took on the assignment of looking at their entire risk management operations and brought in some external consultants.

Commissioner Vach asked if two care coordinators were hired to serve 400 people. Dr. Polakoff replied that there was originally one care coordinator for the pilot test and they were under staffed. It turns out that one care coordinator is needed for 1,500 employees. Now there are two for the 3300 in this particular group. When the project reaches full maturation, there will probably be 4 to 6 care coordinators needed for the entire county.

Commissioner Vach asked what are the typical qualifications of the care coordinators. Dr. Polakoff answered that they would like to have a registered nurse with an ability to relate to people and a sense of business that can deal with numbers who understands corporate culture. Finding that person is not easy because you find some with better people skills and others with better analytical skills. They also have to have physician interface, so in a sense, the county medical director for the center also has oversight over the care coordinators.

Commissioner Vach asked if they are doing any utilization or if it is strictly coordination. Dr. Polakoff answered that they are doing utilization review. They are looking at time off versus standardization. If a person has an umbilical hernia and the standard say they should be all two to three weeks and they are off six weeks, there is utilization. We have already had testimony from the providers that things are changing. Doctor's are now asking 'what is your job?' which a major step forward from where they were a year ago. They are getting anecdotal letters from the employees saying thank you for helping us deal with the HMO. It seems that labor is totally supportive of what they are doing and has given testimony at the board level to voice support.

III. Presentation of 24-Hour Care Program Study: Status Update

Glenn Shor, Ph.D., DWC
Linda Rudolph, M.D., DWC
Nadereh Pourat, Ph.D., UCLA
Bertha Avales, Kaiser Permanente

Dr. Glenn Shor of the DWC Research Unit introduced his associates, Dr. Linda Rudolph, Medical Director of the Division of Workers' Compensation, Dr. Nadereh Pourat, Senior Research Associate, from UCLA, and Bertha Avales, Clinic Coordinator and Administrator of Occupational Health Services at San Diego County Kaiser.

Together they presented a status of the 24-Hour Pilot program. The researchers presented their perspectives and Dr. Rudolph talked about the patient satisfaction survey.

History of the 24-Hour Pilot Program
Glenn Shor, Ph.D., Division of Workers' Compensation

Dr. Shor began his presentation with the rationale for doing a 24-hour care pilot project. Workers' compensation began at a time when other benefits systems were not provided. Since its inception, workers' compensation has become a small part of the overall health and welfare and disability systems being built. However, problems occurred with overlaps in claims and cases as well as gaps in coverage. These overlaps created a lot of litigation between parts of the system where people are trying to fight with the cost of care or disability cost in another system rather than take them in as a single payer. The hope of the 24-hour system is to create efficiencies that will combine these programs and make them work better.

The concept of a 24-hour medical care system doesn't make a distinction between industrial and non-industrial injuries. All care is provided by the same provider or provider group. There is no generally accepted definition of 24-hour coverage. There are many of interpretations presented in various projects being started in both the private and public sector. In its various forms, it can be anything from a system to coordinate and oversee claims coming in on different insurance policies, to a single policy covering all health and disability insurance risks. 24-hour healthcare coverage can include many different things including medical care for work and non-work related conditions, preventive services, disability insurance, and sick pay.

Back in the early 1990's, many factors contributed to the motivation for 24-hour coverage. The rising cost of workers' compensation was one of these motivating factors. Another factor was the increasing difficulty of assessing what was work related and what was not. The project started as both a medical cost control project and a litigation reduction project. Managed care had been successful in other health fields, so many thought that the time was right to apply it in the arena of workers' compensation. This is also a time when the federal effort was looking toward universal health care and there was a fear of cost shifting. It was also finally just an opportunity

to re-design the system. Changes were already starting within the system with health carriers buying out workers' compensation carriers and cross training brokers.

One of the difficulties of 24-hour coverage is how to manage care under workers' compensation when one of the pieces of managed care tends to be a more conservative approach to patient care, a "wait and see what happens" approach. That approach does not fit well in the return to work environment of worker's compensation. So the question was how to bring together these different culture of workers' comp and group health and disability management. There was also the question of how to market the complex product. Other issues were how to strike a balance between employer versus employee choice of medical care and ways to improve return to work outcomes.

Some of the issues to be resolved in 24-hour coverage include fees for premium, co-pay and deductible. In group health, there is usually some co-pay and deductible that the employee pays. In workers' compensation, there is no charge to the employee for medical care. There are also differences between the two sides of group health and workers' comp in terms of the way the policy is written. In workers compensation, there is an occurrence basis that is charged to the policy year. In group health, it is the cost of the treatment during the year of coverage. It does not matter when the injury or illness occurred; it matters when the care was provided.

Dr. Shor continued by saying there was also a question about the experience rating impact on workers' comp. If you took out the health related portion of workers compensation, in a 24-hour project would just be doing experience rating based on disability cost. Other things related to the information technology; how do you combine different technology data system for different projects that were never put together is different reporting requirements, some illnesses and injury have to be reported to under workers' compensation? Under group health, there is no reporting or other regulatory requirements.

As a final note, Dr. Shor explained that this not a new idea. In 1917, two years after the California legislature implemented occupational disease coverage in California, there was an initiative in the state to provide universal health care. It was expected to compliment the workers' compensation system, but the initiative in 1918 went down by the vote of the people, after the idea was marketed by the opposition as being a German idea of social insurance while the United States was at war with Germany.

Putting together a 24-hour product is a coordinated effort involving all the different parties in workers' compensation and group health plans. Early on, it seemed that there was a market for 24-hour coverage. There were many employers looking for ways to cut their workers' compensation costs and deal with disability management in a larger way. There still remains a lot of interest but there haven't been many successful attempts in achieving it.

The cycle of the 24 hour pilots done in California have started with defining the program, proceeding to the application and approval process, then starting up a monitoring system and ending with an evaluation process. California is in the evaluation process now.

In 1992, the governor requested DIR to study 24-hour coverage. Assembly Health Committee chair Bruce Bronzan introduced AB 3757 in February 1992 for DIR to do a small pilot program of 24-hour care. This was amended by the Margolin bill in 1993 and was signed by the governor. The regulation was submitted later in the summer 1993 and the program is currently running. The program was operating until December 31, 1997 as a Pilot program. In encouraging and improving projects, the Division of Workers' Compensation took applications starting in the summer of 1993 and into 1994. Eight applications were received early on in the program, with the first project approval of the Kaiser sight in San Diego County in May 1994 and some other approvals later on that year.

Four plans were ultimately approved, San Diego Kaiser South, Sharp Health Care and TIG Insurance in San Diego County (it never got under way), a joint Kaiser program for Sacramento and Santa Clara County, and a very small program approved in Los Angeles County for Maxicare Life and Health.

First and foremost was the San Diego Kaiser South program. This program began operation in the middle of 1994 and lasted until the middle of 1997. Originally it included about five employers, three self-insured employers including the county of San Diego, and two insured employers including one small insured firm and a dye casting firm. At the end it included about 16 employers and enrollment peaked at about 5,000.

The Northern California Kaiser took the lead of the southern California plan and ran in two counties with four medical care facilities. There were a few state departments that were included as employers in this plan. At its peak, there were 40 employer groups with about 3,000 enrollees.

The Maxicare program was approved at the end of 1994. It went very slowly and nearly didn't get off the ground. At the end, it only had two small employers. The Sharp/TIG program never got off the ground.

One of the disappointments of the program was its size. The original intention of Kaiser's proposal was an expectation that there could be as many as 20,000 people enrolled in San Diego County with the hope of equal number in the North. This occurred at a time when workers' compensation costs began to fall. Firms that were being recruited for this project were given a choice of going into this experimental program or simply taking the discounts that were being offered to them in the market. Many of them decided to just take the discount and the program did not grow to the size that was originally expected.

Dr. Shor then discussed the evaluation portion of 24-hour coverage. The evaluation process as defined in the legislation is very broad in its scope. It is supposed to look at both cost reductions to employers, patient satisfaction, improve health status, access to care, administrative ease, and many other factors. Some of these factors are very difficult to evaluate. DWC is currently in the process of working toward a final evaluation due at the end of this year. The five components of the evaluations are a survey of employee enrollment, claimant survey, employer survey, and claims data analysis.

Patient Satisfaction Survey
Linda Rudolph, M.D., Managed Care Unit, Division of Workers' Compensation

Dr. Shor then introduced Dr. Linda Rudolph to discuss the patient satisfaction survey. She provided a history of what DWC has been doing in the last several years to look at what injured workers think about the medical care they receive. In the group health arena, there has been a lot of work done in assessing the quality of medical care. A key component in the assessment of quality in medical care is looking at the patient perception of their care. Both the National Committee for Quality Assurance and the Agency For Healthcare Policy And Research developed patient satisfaction surveys.

What they found in group health is that if you really want to look at patient satisfaction, it helps to have a standardized survey. A lot of questions were raised about who should do the surveys. Should the organization or an independent party do it? There has been a recent move toward really trying to ensure that independent parties do the survey in the group health arena. DWC is trying to make the survey relevant to the information that is important to the consumer so that the results can be used by purchasers, consumers, and regulators.

Dr. Rudolph said that surprisingly little is known about injured worker experiences in group health. When DWC started looking at the issue, the only non-individual company that surveyed injured workers in California was done back in 1984 by CWCI. DWC looked at a lot of different sources to try and identify what would be the important questions that should be asked about patient satisfaction with medical care. They also talked to an advisory committee consisting of representatives from all the constituencies in workers' compensation about the questionnaire what it ought to look like. They realized that they couldn't stick with the traditional questions that looked at how long a patient sat in the waiting room and whether the doctor explained things to the patient. DWC needed to look at functional outcomes and whether or not people felt like the treatment they received after their injury helped them return to normal function in the workplace and in their lives.

DWC developed a draft questionnaire that contained the following information:

- basic demographics such as age, gender and household income
- the nature of the injury was for which the patient received care
- the patient's access to care
- how quickly the patient was able to receive his/her first treatment
- the overall level of care the patient received
- how the patient felt about it
- the patient's return to work outcome
- did the patient still have pain
- did the patient feel that the injury was still affecting them with their lives today

The draft questionnaire also contained questions regarding workers' compensation issues such as:

- Did the patient consult with an attorney?
- What is the patient's view of the overall of claims handling practices?
- How happy was the patient with his/her supervisors just before their injury occurred?

Specifically with perception of care, DWC wanted to know about how the injured worker perceived the skill of the doctors, whether or not the doctors communicated with them adequately, whether they felt respected by their doctors, and how much information and assistance they felt was available to them.

None of the questionnaires that DWC started with had anything about occupational medicine. Because they were looking at industrial injuries, DWC thought it was important to get a sense of the workers' perception of how well the doctors did in taking an occupational history, understanding the job duties of the patient before the injury, helping the worker to return, and getting some sense of the injured workers' perception of the role of other parties involved in the workers' compensation system. DWC also asked whether or not the patient had group insurance at the time of the injury and what kind of out of pocket payments they had for workers' compensation care, knowing that they shouldn't have any that was not reimbursed. DWC also asked the patient how much choice he/she had and did he/she change physicians.

After the questionnaire was developed with input from the advisory committee, the questionnaire was administered through focus groups of injured workers. To get at the functional outcome of the quality of life after the injury, DWC conducted focus groups with ten to twelve injured workers through the University of California Survey Center. One finding of the focus groups was that injured workers are extremely confused about the workers' compensation in general as well as the medical care system within workers' compensation. It is very hard for injured workers to draw clear line between the healthcare they received at various HMOs and healthcare they received in the workers compensation system. They were getting calls from a lot of people and were not sure who those people were. DWC wanted to get a feeling for whether the case management that goes with something like the 24-hour Pilot makes a difference to workers.

The focus groups demonstrated that workers did not know whether the people calling them were from their employer's human resources department, the insurance company, or the managed care organization. With this feedback, DWC redrafted the survey to keep the focus on workers' compensation care. They also decided to limit the survey to workers with injuries that are more likely to cause sufficient contact with the workers' compensation medical care system in order to identify workers that would be able to comment on it in a meaningful way.

DWC then wanted to perform a broad pilot test of the survey. The survey was mailed to about 800 hundred injured workers who had three or more lost work days, including those with trauma who might have ongoing medical care but sent back to work with restrictions. DWC did some follow-up mailings and then did a very intense follow-up to people that did not mail back the survey so that they could look at how those people differed from the people did mail back the

survey. They received a good response and were able to analyze the difference between initial respondents and the others. DWC used the result of the initial pilot test to revise the survey and that is the survey they are now using to do their evaluation of patient satisfaction in the 24-hour Pilot.

The purpose of the pilot test was to assess the validity and reliability of the survey instrument. DWC feels that the survey now meets those criteria.

Dr. Rudolph then described some of the most interesting results of the survey in order to emphasize the importance of this kind of survey of the injured worker population.

- Sixty five percent of the people that were surveyed said that the injury had some or a big effect on their life today. These people were interviewed a minimum of six months after their injury and some as late as 12 months after their injury.

- About 31% - 33% of surveyed workers said that their doctor talked to them little or none about their work. Dr. Rudolph said that a lot of work needs to be done to get physicians to talk more to injured workers about their work.

- 75% of the injured workers surveyed said that the doctor understood the impact of the injury on their ability to do their job. But only 56% of the injured workers surveyed said that their doctor told them how to avoid re-injury when they returned to work. Again, there is a lot of work to be done to improve these numbers.

- Another surprising result was when injured workers were asked about pain. A significant proportion of workers reported that during the four weeks previous to answering the survey, they had bodily pain that was related to the injury and 40% said they have that pain all the time or almost every day. Although workers were selected with more serious injuries, there is still a perception by the injured workers of the impact of their injuries to be significant for quite some time after the injury.

- When asked how satisfied they are with the health care they received for their injury, 17% of the injured workers surveyed said they were dissatisfied and 9% said they were very dissatisfied. These figures express somewhat more dissatisfaction with workers' compensation care then what is typically seen in the satisfaction surveys of group health. But the caveat is that the same questionnaire is not being administered in both arenas.

DWC received funding from the Robert Wood Johnson Foundation to expand the use of this pilot to incorporate the 24-hour pilot group as well as other groups of injured workers. They just completed telephone interviews of 800 hundred injured workers that have temporary disability and are cleaning up the data so they can analyze it. There are four groups of injured workers that were not included in the interviews and DWC hopes to look at whether or not there are any significant differences in satisfaction between the four groups. The difficulty of such a study is

that there is a bigger lag time between date of entry and the interview date between 24-hour pilot enrollees.

Dr. Rudolph reported that after DWC analyzes and reports on the results of the 24-hour Pilot evaluation and the bigger survey of injured workers, whatever they find about the kinds of questions on the survey will be more meaningful in a larger study of the population. DWC wants to start using this instrument more widely, so they have made the instrument available to other people in the country to look at what injured workers think about medical care and how they perceived their outcome after injury. They are also looking into whether there is a way to create an ongoing mechanism to independently administer the survey to larger groups of workers and provide feedback to individual organizations about how their workers feel about the care they get. In addition, they are looking into establishing a benchmark from a much broader pool of workers so that organizations can see their health care delivery system as compared to others.

The potential uses for this survey are many. Employers can use this survey to look at what's happening with injured workers in their work force improve their system. They can also use it to assist in purchasing selection decisions about where to send injured workers for medical care and to negotiate what medical providers. Ideally, workers who would be able to use results from this survey to help make choices about what to do with their medical care --do they or don't they want to get involved in something like the 24-hour Pilot? Managed care organizations and providers can use the results for their own internal quality improvement projects. The agency can use it to look at what is happening with the quality of care for injured workers in conjunction with other data that is collected to identify problem areas and work with the community to improve the care of injured workers.

At the conclusion of her presentation, Commissioner Vach asked Dr. Rudolph if the 800 injured workers who were surveyed were contacted by telephone. Dr. Rudolph replied that they did use the telephone in order to get a better response rate. Using funds from the Robert Wood Johnson Foundation, they were able to offer $5 for each person who answered the questions. When done by mail previously, the response rate was 33%. But she said that she feels confident that DWC will not see big differences in satisfaction with medical care between people who returned the survey and those who didn't. Even if the survey response is not fabulous, they feel like they will get a good sense of what is happening.

California's 24-Hour Coverage Demonstration Pilot -- Analysis of claims data 1991-97
Nadereh Pourat, Ph.D. at UCLA Center for Health Policy Research

Dr. Nadereh Pourat from the UCLA Center for Health Policy Research made a presentation on behalf of Dr. Kominski who could not attend. The title of her presentation was *California's 24-Hour Coverage Demonstration Project.* In this study they analyzed the claims data from 1991 to 1997. The caveat is that it does not include self-insured organizations. All of the groups were insured by the State Compensation Insurance Fund.

The goal of the study was to evaluate the effect of the 24-hour coverage demonstration pilot in California. The study looked at changes in the costs of worker's compensation programs and changes in the types of workers' compensation claims. She emphasized that the results are only preliminary.

She continued with a description of the analysis design. The ideal analysis design is to look at the control group firms versus the 24-hour firms. Data submitted from the two different types of firms were matched on a number of characteristics that were felt to be important. For example, they were matched under claim experience to type of industry and the combination of types of jobs those industries have and whether Northern or Southern California. Data was collected from both the control group firms and the 24-hour group firms. They also collected data prior to the implementation of the 24-hour project and after the implementation for both groups.

The final comparison will be between those that employees that enrolled in the Kaiser on the Job program and employees that did not enroll in the program and received their occupational health elsewhere or at Kaiser but not as part of the Kaiser on the Job program. What UCLA does not have at this stage is the final comparison between the Kaiser on the Job enrollees and the non-Kaiser on the Job participants. The data being presented now is mostly aggregate.

Of the 24-hour group, UCLA received data from 65 firms, about fifty-five of which had claims. The majority of the claims for both groups were from a couple of large firms. There were about 6,000 individuals that made workers' compensation claims. The number seems large because UCLA looked at all seven years of data and looked at before and after data for all groups that agreed to participate. A larger number of firms in the control group agreed to provide their information. The control group made fewer claims.

UCLA will look at the aggregate total payments made from 1991 to 1997. What they are looking at is also the actual amount paid, as it is different from the amount that is projected at the time the claim is made. The 24-hour group started with higher costs and interestingly enough the cost seemed to decline faster. Dr. Pourat again stressed that 1997 is an incomplete data year at this point. UCLA will be getting the entire data for 1997 at a later date. But overall, there are indications that there have been additional effects by the 24-hour project.

Just below a thousand claims were made in 1991 and increased later for the 24-hour group. For the control group there doesn't seem to be much of a change in the number of claims made.

Total payments made per claim by year declined in both groups. Dr. Pourat said that the two groups are similar and it will be interesting to see whether there has been a decline in the amount of payments made per claim as an effect of the 24-hour project.

Next, Dr. Pourat examined the types of services that were paid for before and after the implementation of the project for both groups. Physician services are always the number one type of care that is provided. Before implementation of the 24-hour project, the second type of care was predominantly permanent partial disability. After implementation of the project, the

second type of care switches to hospital. The third ranking service prior to the project were hospital or evaluation types of services. Afterwards, it is payment to the injured or disability payments. There is a similar pattern for the control groups. There does not seem to be lot of difference between the two groups in the type of services that were provided.

Dr. Pourat then drew some preliminary conclusions from the data. It appears that program expenditures may have decreased faster after implementation of the 24-hour project. Expenditures per claim may have decreased more for the 24-hour group than the control group. And finally, no significant changes appear in the patterns of injures or accidents post 24-hour implementation.

Kaiser Permanente San Diego 24-Hour Care Project
Bertha Avales

Bertha Avales representing Kaiser Permanente, San Diego described their 24-Hour Care Project to the Commission. San Diego Kaiser Permanente had about sixteen employers participating in the plan. There was an initial enrollment of 3,368 that increased to 5,000 by the end of the pilot year.

For each year of the program, Kaiser conducted a return to work study of five consecutive weeks to try to determine if they are returning injured workers back to the work field quickly. As demonstrated by Ms. Avales' slide presentation, 73% of all injured workers were returned to work during that five-week period without any temporary total disability or modified duty. 13% were returned with less than three days TTD for an overall 86% return to work without any total temporary disability to modified duty with less than three days.

Ms. Avales provided a brief description of the three-year program managed at Kaiser, San Diego. The Occupational Health Service Department at their Medical Center was the initial point of entry for injured workers. Primary care physicians in outlining areas were also trained in case some injured workers went to the Outlining Medical Center instead of the OHS Department. But there was good communication with the employer groups and about 80% of the injured workers were seen in Kaiser's Occupational Health Services Department. About 1% of injured workers came in through the Emergency Department, 5% came in through the primary care department where there were primary care physicians trained in occupational health, 10% were provided specialty services, and 5% received outside specialty services.

Of the referrals, 73% were for physical therapy and occupational therapy, 18% were for specialty departments such as general surgery, orthopedics, neurology and neurosurgery, and 9% were for outside specialty referrals.

Ms. Avales presented slides that showed the breakdown of specialty services offered by Kaiser San Diego to injured workers. Most of the referrals were for strains and sprains, neurology or repetitive injuries such as carpal tunnel and upper extremities.

Where necessary, Kaiser made referrals to outside specialists. Of those outside referrals, 46% of those were for physical therapy services not provided by Kaiser such as water therapy for knee injuries, 43% were for chiropractic services, 10% for acupuncture, and 1% for dental services.

Of the types of cases that were seen in the Kaiser program, the number one injury was overuse of the upper extremities. Upper extremities overuse, neck injuries and shoulder injuries combined represent about a third of all industrial injuries. Back injuries are the second most frequent injury.

Kaiser conducted a satisfaction survey of the injured workers seen under the project during June 1994 through 1995 to determine if they were happy with the program. The survey asked participants if they were satisfied with access to appointments in occupational medicine. 75% of the participants that were seen in the first year varied between being satisfied and very satisfied. Very few participants were dissatisfied. Another question asked if participants were satisfied with the medical care they received in occupational medicine. Again the range is about the same with about 70% of the participants ranging from good, satisfied to very satisfied. The next question asked whether Kaiser's occupational providers addressed their worker's needs and about 65% to 75% of the participants were satisfied. Finally, they asked the participants if they would re enroll in this type of a program and about 80% of the participants expressed interest in re-enrolling.

Through the pilot program, Kaiser found that it improved its communication with insurance carriers as well as employers so much so that all of the employer groups that participated in the pilot have listed Kaiser under their preferred provider for services at the end of the project. Ms. Avales said that Kaiser believes it is a successful program.

Commissioner McLeod asked which state agencies were involved in the Kaiser project. Dr. Shor said that participants included some offices of the Department of Motor Vehicles (DMV), the Employment Development Department (EDD) and the Department of Personnel Administration (DPA) in Sacramento.

Commissioner Vach asked who acted as the 24-hour carrier. Mr. Shor replied that the State Compensation Insurance Fund (SCIF) was the administrator.

Commissioner Vach asked if any satisfaction surveys were completed for non-Kaiser on the job participants. Ms. Avales replied that Kaiser performed their regular satisfaction survey and a full-blown satisfaction survey was performed through Kaiser's alliance with SCIF. Those satisfaction surveys run about the same as the Kaiser on the Job with a 70% - 80% satisfaction rating.

Commissioner Vach asked if similar surveys were conducted outside the alliance for regular Kaiser members. Ms. Avales replied that many surveys are done of Kaiser's membership which generally show an even higher satisfaction rate.

IV. Update and Discussion Regarding Commission Studies and draft Annual Report Christine Baker, Executive Officer

Executive Officer Christine Baker reported that Commission staff has been very active in carrying out the various Commission projects.

CHSWC 1997-98 Annual Report

Ms. Baker reported that two recommendations were added to the annual report and the draft version made available to the Commissioners. The report is based on Commission's studies and reports in addition to input from various task forces and advisory groups. She requested Commission approval of the draft annual report so it could be finalized.

Commissioner McLeod motioned for approval of the draft annual report. Commissioner Steinberg seconded the motion. The draft annual report was approved by a unanimous vote of the Commission.

Permanent Disability Study

Ms. Baker reported that the Permanent Disability Policy Advisory Committee met on Wednesday, September 2, 1998. During the meeting, the research team provided preliminary data regarding economic conditions and its impact on wage loss. They also provided a briefing on the preliminary analysis of WCAB case settlement data.

Stating that the PD Advisory group has proven to be a good way to get feedback, Ms. Baker reported that the PD Advisory group asked Commission staff to prepare a process paper for technical feedback. Staff is currently developing the process paper.

As the next contract is developed, Ms. Baker requested additional funding for discussions and meetings regarding methodology that are being requested by the state. The cost and details have not yet been worked out, but she promised to keep the Commission informed as they are developed. There are more demands than anticipated on the RAND team to discuss the research findings.

She then introduced Robert Reville of RAND to provide a status report on the self-insurance component of the study. Dr. Reville discussed several items.

Economic Conditions

Dr. Reville reported that preliminary results on the study of economic conditions were shared with the Permanent Disability Policy Advisory Committee. He emphasized that the results are subject to change. They were presented to elicit feedback and allow them to keep their constituents informed. He stated that RAND is continuing the analyses and conducting new analyses in response to feedback from the advisory committee. After the analyses undergo technical review, the results will be presented to the Commission and then to the PD Policy Advisory Committee. The study should be complete in December.

Self-Insured Study

Dr. Reville reported that the survey of self-insured firms is complete and they are pleased with the response. They contacted 150 public employers and 150 private employers and requested that they send their claims data from 1991 through 1995. RAND received data from 81 private employers and 90 public employers.

Dr. Reville thanked the self-insured employers who submitted data. He also expressed appreciation to Joe Markey, President of the California Self-Insurers Association, for his help in facilitating a high response rate and to Mark Ashcraft, Manager of DIR Self-Insurance Plans, for his cooperation with the study. He said that it is RAND's expectation that the study will be a significant contribution to policy in California as well as national policy.

RAND is making arrangements to link the data to the Employment Development Department wage data in order to replicate the study performed on insured data. RAND is currently cleaning up the data and making those arrangements.

Although RAND initially committed to providing results this fall, they are behind schedule due to an underestimate of the amount of time required for employers to compile the requested data. RAND decided to give them an additional three months or so to respond to the request. RAND is still receiving data from employers but plans to cut it off soon.

RAND's plan is to make a presentation of preliminary results to the PD Policy Advisory Committee in December for their feedback and then pull together a final report and have it technically reviewed. The Commission will receive a briefing on those results early next year.

Other States Study

Dr. Reville reported that the National Institute of Occupational Safety and Health (NIOSH) has funded the comparative study of wage loss in five states. NIOSH was established by the Occupational Safety and Health Act of 1970. They are part of the Center for Disease Control and Prevention and are the only federal institute responsible for conducting research and making

recommendations for the prevention of work related illnesses and injuries. As a federal agency, NIOSH is not associated with any political positions or interest groups in workers' compensation in California. Proposals are peer reviewed for scientific quality and consistency with the goals of the agency. Their primary goal is conducting research and providing scientifically valid recommendations for protecting workers.

To ensure accountability of the research to the Commission and to the workers' compensation community in California, the analysis of California data will be funded separately by the Commission. The Commission will receive a separate report with the implications for California. The analyses of other states will be paid for by NIOSH. The Commission contribution will pay for the analysis of the California data, a comparison of the results for other states, and a Commission publication to occur over a two-year period.

Mr. Reville reported that Dr. Leslie Boden of Boston University is the principal investigator of the NIOSH proposal. Mr. Reville will head the research of the California component for RAND. In addition to California, the proposal calls for analyzing wage loss in Washington, Oregon, Wisconsin, and Florida. Other states may also be included in the analysis. DWC Administrative Director Casey L. Young has arranged for RAND to present the analysis plan at the IAIABC meetings in order to recruit the involvement of other states.

Dr. Reville concluded by stating that with the combination of NIOSH and Commission funding, California will benefit from a million dollar project designed to improve the understanding of wage loss for injured workers and identify the best ways to reduce it.

Commissioner Steinberg asked Mr. Reville if the data analysis of the self-insured employers would impact RAND's preliminary findings that were presented at the PD Policy Advisory Committee meeting. Dr. Reville replied that the analysis would impact the preliminary findings. Although RAND has received the claims data, they do not yet have the wage data and both sets of data are needed to conduct the analysis.

Commissioner Steinberg asked Dr. Reville to clarify how California will benefit from a NIOSH funded study of the wage loss in other states. Dr. Reville replied that NIOSH funded study of wage loss in other states will be made consistent with the California study. RAND will analyze the data to find out how the experiences of workers in California compare to other states. In addition, RAND will look at the institutions, industries and the demographics of other states and try to identify differences in practices such as return to work or policies that may be helpful in explaining differences that are found across states. Ultimately, perhaps these findings will allow RAND to identify policies that will help to reduce wage loss in California. He clarified that RAND will only receive $62,000 from NIOSH. The additional amount of $752,000 needed to fund the study will be given to Boston University and Michigan State University.

Commissioner Steinberg asked if Dr. Boden collaborated with RAND on the initial study of permanent disability in California. Ms. Baker replied that Dr. Boden did not work with RAND

on the study but did participate in the CHSWC Permanent Disability Summit held in South San Francisco in November of 1997.

Audit Study

In April of 1998, the Senate Industrial Relations Committee and the Assembly Insurance Committee jointly requested that the Commission undertake evaluation of the effectiveness of the audit function of the DWC. At the last meeting, the Commission requested that Commission staff flesh out the recommendations that the project team had developed. In the interim, staff met with the Audit Advisory Committee to provide detailed recommendations for the audit process, to detail the proposed changes to the penalty structure, and to provide details on simplification of payment of compensation. Commission staff continues to work with the Advisory Committee to work these details out.

Some of the issues currently being worked out include auditing the entities vs. the locations, whether there should be penalties assessed on entities that pass certain standards, and developing an estimate of the impact of the various alternatives for penalties. Discussion is on going regarding the simplification of compensation benefits and staff is currently estimating the impact of escalating pay out of PPD.

Ms. Baker said that she hopes to have a detailed report for the Commission by November.

Workers' Compensation Prototype Information

The Commission contracted with the UC Berkeley Labor Occupational Health Program (LOHP) for the development of prototype instruction written material and a video. Ms. Baker informed the Commission that the video is now accessible on the internet at the Commission web site. DWC is receiving requests for the written materials, and have made the materials and video available to injured workers at statewide Information and Assistance Offices. In addition, the fact sheets are now available in Spanish.

Ms. Baker said that there is quite a demand for the fact sheets and she is pleased with the results.

The next phase of this project will be the development of a return to work factsheet. Working with LOHP, Commission staff will also improve the format of the existing factsheets, update the information, and evaluate the effectiveness of the factsheets. In addition, Commission staff will inform employers how to use the materials to fulfill their legal obligation to inform workers and make recommendations to clarify the labor code and the regulations that are confusing and conflicting.

Young Worker Study Group

The Commission is funding a statewide taskforce known as the California Study Group on Young Worker Health and Safety. It is charged with coordinating strategies to protect young people from work related illnesses and injuries. The study group is composed of groups and individuals dealing with California youth employment and education issues as well as others who plays a role in educating and protecting young workers. The statewide study group continues to meet quarterly and has met twice this year and will meet again in September and December. The group has divided into subcommittees to focus on further exploring and developing several key recommendations including recommendations to develop a resource center, to improve the work permit system, and to create a statewide public awareness campaign. Ms. Baker said that she would brief the Commission on the status of the sub-committee work at the next meeting.

In addition to a public awareness campaign and exploring the feasibility of a resource center, the Youth Study Group is convening a meeting of enforcement agency representatives to further explore related recommendations. That meeting will be held in October. After the recommendations have been made, more detail and a meeting with agency heads will be convened to explore these recommendations and other innovative approaches to coordinating the education outreach and enforcement activities of these agencies. Ms. Baker expressed hope that this would occur at the beginning of 1999.

The next meeting of the Youth Task Force is schedule for September 24, 1998.

Illegally Uninsured Employers

Ms. Baker reported that the tracking of illegally uninsured employers is ongoing. The Department of Industrial Relations (DIR) has embraced this project and is carrying it out as "Operation Insure". By the next meeting in November, the data on the pilots should be finalized and a report made to the Commission on the success of that program.

Carve Out Project

The research team is currently finalizing the carve out data and will circulate a report to the advisory group within the next several weeks for feedback. Ms. Baker said that she expects the report to be presented for finalization at the November meeting.

New Projects

Ms. Baker reported that Commission staff is in the process of developing contracts for all the projects proposed for the 1998/99 fiscal year. Current fiscal year projects are the continuation of the PD RAND project, the Benefit Notice Simplification project, the continuation of the Medical

Legal data analysis, the development of Return to Work project, the Young Worker Taskforce, and the Audit project.

The continuation of the RAND study permanent disability project is the largest one. The Commission received a $1.2 million augmentation in its budget to continue work in this area. This project requires $82,000 from existing Commission funds to address phases 1 and 2 of the RAND continuation. A return to work analysis and proposed revision of the PD schedule have already been approved. Phase 3, analysis of the wage loss and return to work in other states, requires $85,000 per year for 2 years, and about $105,000 for the third year from Commission funds. In addition, RAND obtained $250,000 per year from NIOSH for research on other states. We will be requesting a contract with RAND to conduct most of the work via interagency agreements between EDD, DIR, WCIRB, DOI and UC Berkeley to assist the project.

Inter-agency agreements are also being prepared for the Benefits Notice Simplification project, the Injured Worker Return to Work Prototype project and the Medical Legal study.

V. Other Business/ Public Questions/ Comments

There were no public comments or questions.

VI. Adjournment

Commissioner O'Hara adjourned the meeting at 12:05 p.m.

Future Meetings

The next meeting of the Commission will be held on **Wednesday, December 16, 1998** at the Secretary of State's Office Building, 1500 11th Street (at "O" Street) in **Sacramento**. (There will be no Commission meeting in November 1998.)

Approved: Respectfully submitted,

Tom Rankin 12-16-98 Christine Baker

Tom Rankin, Chairman Date Christine Baker, Executive Officer